STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	05/27/2011

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WESTMINSTER HEALTH CARE CENTER	2210 GREENTREE NORTH CLARKSVILLE, IN47129

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: May 23, 24, 25, 26, 27, 2011 Facility number: 000100 Provider number: 155191 AIM number: 100266130 Survey Team: Avona Connell, RN TC Donna Groan, RN Dorothy Navetta, RN Gloria Reisert, MSW Census bed type: SNF/NF: 79 Residential: 84 Total: 163 Cesus payor type: Medicare: 14 Medicaid: 35 Other: 114 Total: 163 Sample: 16 Supplemental sample: 08 Residential sample: 08 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/6/11 by Jennie Bartelt,	F0000	RE: Provider Number: 155191 Facility Number: 000100 AIM Number: 100266130 June 16th, 2011 Kim Rhodes , Director Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, In 46204 Dear Ms. Rhodes Please find Form CMS-2567 with the plan of correction for the deficiencies sited during our recertification and Indiana State Licensure survey conducted at Westminster Health Care Center on May 23rd through May 27th, 20011. I can be reached at 812-282-9691 ext 123 if you would have any question or comments regarding the enclosed documents. Sincerely Floyd Shewmaker Administrator Westminster Health Care Center **Preparation and execution of this plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provisions of federal and state law. Allegation of Compliance: For the purposes of any allegation the Westminster Health Care Center ("Facility") is not in substantial compliance with federal**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	RN.		**requirements of participation, this response and plan of correction constitute Westminster Health Care Center allegation of compliance.Date of compliance:**June 26th, 2011	
F0248 SS=D	The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure a resident who liked wheeling/walking outdoors was offered the opportunity for 1 of 5 residents whose activities were reviewed in a sample of 16. (Resident #95) Findings include: The clinical record for Resident #95 was reviewed on 5/25/11 at 9:20 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia and depression. The resident was admitted to the facility on 3/10/11. The Initial Activity Assessment, dated 3/10/11, completed by Activity Employee #1, included, but was not limited to: "Activity Interests Current Walking/Wheeling Outdoors Assessment Comments and Treatment Plan For Resident Staff will invite and encourage her to attend group activities for fun,	F0248	**Plan of Correction (F 248) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident # 95 is no longer at the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** 1. Resident Care Plans will be reviewed by Activity Director and Interdisciplinary Team each assessment period to assure that those residents indicating an interest for walking/outdoor activities have been identified and appropriate Care Plans initiated. The Activity Calendar will be updated to include outdoor activities. 2. Care Plans not meeting the interest indicated for resident and or resident activity assessment will be revised and will be updated when interest changes no less than quarterly	06/26/2011

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	entertainment and social stimulated (sic). Staff will escort her to and from any activities of her choice." The Activity Director provided the March 2011 Activity Calendar on 5/27/11 at 10:30 a.m. From March 10 thru March 22, 2011, a walking/wheeling outdoors activity was not scheduled. In interview with the Activity Director on 5/27/11 at 10:30 a.m., he indicated the Resident Care Plan for activities was standard and had not been individualized to Resident #95's specific interests. The care plan had not been updated since admission. 3.1-33(a)		and as needed. 3. Offer activities that meet the individual needs and interest of each resident found not met. 4. All staff to encourage, invite, escort and assist resident with activities of interest per schedule. **What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;** 1. Activities will be offered and scheduled according to Plan of Care to meet all residents individual needs and interest per resident's interest and or resident's activity assessment upon admission and reviewed at least quarterly.. 2. Care Plans will be personalized upon initial interest assessment to meet individual needs and interest of all residents. Activity staff will complete initial interest assessment upon admission and review at least quarterly or as needed to assure resident's needs are being addressed. Those Activities identified will be cross-referenced to the Activity Calendar to assure the interest of the residents are being met. 3. Care Plans will be reviewed every every quarterly assessment period, Annually and as needed. Caer planswill be revised based on residents likes/ dislikes and changes in their personal needs and interest. **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., What Quality Assurance program will be put into place; 1. Resident Care Plans will be reviewed by the Director of Activities & Interdisciplinary Team every quarterly assessment period, Annually and as needed to assure resident needs and interest are being met. All Care Plans will be reviewed at least quarterly by the Interdisciplinary Team. 2. Director of Activities will monitor monthly participation records of all residents and make adjustments to personalize Care Plans and Monthly Scheduled Activities to meet the needs and interest of all residents. 3. Director of Activities will document in residents progress notes any changes of need, interest or participation pertaining to Activities of interest. **By what date will the systemic changes will be completed.** 06/26/11	
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure social services assisted the interdisciplinary team in planning and revising the plan for care of a resident at risk for and with history of elopement from the facility for 1 of 5 residents reviewed for social service assistance in a sample of 16. (Resident #95.) This deficient practice had the potential to	F0250	F2503.1-33(a)483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICESWhat corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice: 1. A review of each current resident's chart (that have been targeted as at risk for elopement) will be completed to review past interests and to	06/26/2011

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	effect 5 additional residents identified by the Director of Nursing as an elopement risk and wearing a wanderguard. (Resident #6, 13, 24, 65, 45) Findings include: The clinical record for Resident #95 was reviewed on 5/25/11 at 9:20 a.m. The resident diagnoses included, but were not limited to, Alzheimer's dementia and depression. The resident was admitted to the facility on 3/10/11. The Initial Wandering Assessment Guide, dated 3/10/11, indicated the resident should have a 90 day signaling device (Wanderguard) on for assessment purposes. Wandering behaviors can increase with changes in residence, so consider monitoring the resident until the next assessment period or until you can determine the elopement risk has decreased..." The Social History & Assessment form completed on 3/17/11 by the Social Service Director, included but was not limited to, VII (7) Resident's Special Interests: "outdoors" VIII (8). Mental Status Cognitive Alert; Short-Term Memory Poor; XII (12) Adjustment "doing okay but wishes to go home" Nurses Notes, reviewed at this time, included, but were not limited to: 3/14/11 1600 (4 p.m.) "Res attempted to get out of front door this shift. Asking 'Is this how I get to the 3rd floor?'...Will cont. (continue)to monitor for exit seeking." 3/16/11 1600 "Res. is very confused and will exit seek @ times. Res wheeled herself to the front door this shift and stood up from w/c (wheelchair)..."		ensure these (past interests) will be added or included in their care plan which may include activities which may assist in decreasing wandering behaviors.2. The review and addition of past interests being added to care plans (for those residents considered an elopement risk) will be ongoing to include all those future residents as well.3. Resident # 95 was discharged to a secured Nursing Facility for her safety. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will take place:1. A meeting of the Interdisciplinary Team will be held when residents have increased exit seeking behaviors. This is to include those already considered at risk for elopement and those that may be exhibiting new exit seeking behaviors. The care plan is to be updated and reviewed to include possible areas of past interest to assist in decreasing exit seeking behaviors.2. A review of each resident's chart (that have been targeted as at risk for elopement) will be completed by Social Services to ensure past interests are utilized as possible interventions to decrease exit seeking or wandering behaviors. 3. This is to be ongoing to include all future residents targeted as being at risk for elopement as well. What measures will be put into place or what systemic	

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	3/18/11 8 p "[family member] wants exit seeking behavior discussed with Dr. [named] on visit Tues. 3/22/11." 3/19/11 1300 (1 p.m.) "...Short term memory is very poor. Res gets up from w/c and ambulates ad lib. She needs constant reminder not to ambulate unassisted. She wanders to doors throughout shift and pushes on door till alarm sounds..." 3/20/11 7:30 pm "Res. left facility and was found on the porch of A.L (Assisted Living). Facility policy was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." The Social Service Progress Notes begin with 3/17/11 which included, but were not limited to, "care plan to be reviewed...She is wearing a wander guard bracelet as res. was frequently a walker @ ALU (Assisted Living Unit) and spent much X inside with res varying cognition nursing feels res needs to stay in the NF (Nursing Facility) for her own safety will care plan code cognition and desire to return home..." On 3/22/11 social services noted that the resident had left the facility to go to her apartment. The Resident Care Plan dated 3/10/11 included, but was not limited to: "Needs/Problems Res. at risk for elopement; Goal/Objective Res will have no episodes of unknown whereabouts's daily thru next review; Approach/Action/Plan wanderguard in place, update wandering assessment quarterly		changes will be made to ensure that the deficient practice does not recur: 1. When residents (new to the facility and also those already here considered an elopement risk) begin exit seeking or increase exit seeking behaviors, the Interdisciplinary Team will meet and review those residents care plans to ensure activities and past interests are included in residents care plans. Immediate interventions will be implemented by Nursing staff upon increased behavior prior to the meeting of Interdisciplinary Team to include the updating of the resident's Care Plan. These interventions may include but not limited to , toileting, food/fluids, activities and physician notification.2. Each resident considered an elopement risk will also be added to the behavior books which are at each Nurses Station. In those behavior books, interventions (to include past interests) will be available for all staff to review as needed. The Interdisciplinary Team will review the Resident Behavior Plans monthly and as needed and changes will be made as appropriate. All Staff will be Inserviced by 6/26/2011 regarding the Behavior Management Policy and Procedures. 3. Monthly elopement drills are to be conducted by Social Services Director to ensure staff know how to react in the event an actual elopement were to occur. The	

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	and prn (as needed), update elopement manual, check placement & functioning of wanderguard as scheduled on MAR (Medication Administration Record). Documentation was lacking the resident care plan had been revised prior to and after the elopement. Review of the Social Service Director job description dated July 17, 2007, provided on 5/27/11 at 8:20 a.m., by the staff development coordinator, included, but was not limited to: "Purpose: The Social Service Director will assure that the medically related emotional and social needs of the resident are attained/maintained on an individual basis...Responsibilities...15. Is responsible for overseeing elopement prevention protocols including the elopement book...23. Will maintain a productive working relationship with other department supervisors and coordinate social services to assure that daily social services can be performed without interruption and ensure that a team effort is achieved in developing a comprehensive plan of care...37. Is responsible for developing a thorough, accurate, and comprehensive resident assessment of psychosocial needs through chart review and resident observation on all admission, significant changes, discharges, quarterlies, and as needed according to and within the time frame specified by current state and federal rules		Elopement Policy and Procedure will be Inserviced by 6/26/2011. How the corrective action(s) will be monitored to ensure the deficient practice will not recur ie what QA program will be put into place: 1. Social Services Director will review all residents targeted as an elopement risk each month. The review will include the Elopement Books and Behavior Books. During that review Social Services will be responsible for seeing that past interests are included in the Care Plan interventions and also at that time Nurses Note and Behavior Book to be reviewed for effectiveness of the current interventions. This is to be a part of our QA program and the findings reported at QA meeting monthly.2. Monthly Elopement Drills to be held by Social Services. This will be a part of our QA program and the results of those drills (how staff responded, any concerns etc.) will be reported monthly in our QA meetings. By what date the systemic changes will be completed: 6/26/11	

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	and regulations, and per facility policy and procedures. 38. Is responsible for developing a through, accurate, comprehensive, and individualized resident care plan on all admissions, significant changes, discharges, quarterlies, and as needed according to and within the time frame specified by current state and federal rules and regulations, and per facility policy and procedures. The plan of care should reflect possible or identified problems//needs of the resident and the goals to be accomplished for each problem identified. 39. Is responsible for ensuring that complete, accurate, and comprehensive Social Service progress notes that are completed on all admissions, significant changes, discharges, quarterlies and as needed according to and within the time frame that is specified by current state and federal rules and regulations, and per facility policy and procedures. 40. Will review nurses' note and other disciplinary notes to determine if the plan of care is being followed. Will report problem areas to the Director of Nursing Services..." In interview with the Social Service Director on 5/27/11 at 12:05 p.m. indicated the care plan was not revised and updated.			

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	3.1-34(a)			
F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on record review, observation and interview, the facility failed to ensure the care plan was revised as the resident's status changed related to exit seeking and/or cutting off the Wanderguard for 2 of 16 sampled resident care plans reviewed. (Residents #95, #8) Findings include: 1. The clinical record for Resident #95 was reviewed on 5/25/11 at 9:20 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's dementia and	F0280	**F280 483.20(d)(3),483.10(k)(2) Right to participate planning Care-Revise CP The facility will use the Risk to Wander Assessment to determine the need for a comprehensive plan of care for each resident . The comprehensive plan of care will be developed immediately by the nurse after the completion of the Risk to Wander assessment that indicates the risk to wander or when the resident exhibits wandering/ exit seeking behavior. The plan of care will be prepared by the nurse**	06/26/2011

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	depression. The resident was admitted to the facility on 3/10/11. Nurses Notes reviewed at this time, included, but were not limited to: 3/14/11 1600 (4 p.m.) "Res attempted to get out of front door this shift. Asking 'Is this how I get to the 3rd floor?'...Will cont. (continue) to monitor for exit seeking." 3/16/11 1600 "Res. is very confused and will exit seek @ times. Res wheeled herself to the front door this shift and stood up from w/c (wheelchair)...." 3/18/11 8 p "[family member] wants exit seeking behavior discussed with Dr. [named] on visit Tues. 3/22/11." 3/19/11 1300 (1 p.m.) "...Short term memory is very poor. Res gets up from w/c and ambulates ad lib. She needs constant reminder not to ambulate unassisted. She wanders to doors throughout shift and pushes on door till alarm sounds...." 3/20/11 7:30 pm "Res. left facility and was found on the porch of A.L (Assisted Living). Facility policy was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation		**immediately. The interdisciplinary team, and other appropriate staff in disciplines as determined by the residents needs, and the extent practicable, the, participation of the resident, the residents family or the residents legal representative will periodically review and revise the comprehensive plan of care. The facility will develop a comprehensive plan of care for each resident with a history of removing their Wander Guard device. The comprehensive plan of care will be developed by the nurse immediately after identification of the intent to remove or the history of removal of Wander Guard device. The interdisciplinary team, and other appropriate staff in disciplines as determined by the residents needs, and the extent practicable, the, participation of the resident, the residents family or the residents legal representative, will periodically review and revise the comprehensive plan of care. CORRECTIVE ACTION: For those residents found to be affected by the alleged deficient** practice: Resident # 95 This resident was discharged from our facility on 03/22/2011. Resident # 8 The Risk to Wander assessment was	

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	had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the Wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. The Resident Care Plan dated 3/10/11 included, but was not limited to: "Needs/Problems Res. at risk for elopement; Goal/Objective Res will have no episodes of unknown whereabouts's daily thru next review; Approach/Action/Plan Wanderguard in place, update wandering assessment quarterly and prn (as needed), update elopement manual, check placement & functioning of Wanderguard as scheduled on MAR (Medication Administration Record). Documentation was lacking the resident care plan had been revised after the elopement nor after the increase in exit seeking. 2. The clinical record for Resident #8 was reviewed on 5/24/11 at 10 a.m. The resident's diagnoses included, but were not limited to, dementia and cerebral vascular disease. On 5/26/11 at 10:30 a.m., Resident #8 was seated in a wheelchair. During interviw at this time,		updated on June 3rd, 2011. The combination of the categories indicated the resident is at risk to wander. He also has a history of removing his Wander Guard device. The plan of care was updated to include a Wander Guard device to the right hand and to the base of the residents wheel chair. All current residents identified as at risk to wander and with a history of removal of Wander Guard have had an updated Risk to Wander assessment completed and care plans reviewed and updated if needed for both. **To identify other resident's having the potential to be affected by the alleged deficient practice:**All residents have the potential to be affected by the alleged deficient practice. Nurse managers will review all care plans for those residents identified at risk to wander / exit seeking by the completion of the risk to wander assessment or with a history of removing their Wander Guard device. A Comprehensive care plan will be in place immediately when identified as at risk to wander**.** The plan of care will be reviewed by interdisciplinary team, and other appropriate staff in disciplines as determined by the residents needs, and the extent practicable, the, participation of the resident, the residents family or the residents legal representative, and periodically reviewed and revised	

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	LPN #3 was asked to locate the resident's Wanderguard. She was observed searching the resident's wrists, ankles and wheelchair for Wanderguard. The Wanderguard could not be found. In interview with LPN #3 at 10:35 a.m., she indicated the resident "likes to remove them (Wanderguard). He cuts them off." The Resident Care Plan dated 3/22/11 indicated "Needs/Problems: Res. at risk for elopement; Goal/Objective: Res will have no episodes of unknown whereabouts daily thru next review; Approach/Action/Plan: Wanderguard in place, update wandering assessment quartly (sic) and prn (as needed), update elopement manual, check placement & function of Wanderguard as scheduled on MAR. Documentation was lacking of a problem and interventions for the resident cutting off his Wanderguard. On 5/27/11 at 12:35 p.m., the Director of Nursing provided the undated Policy and Procedure for Care Plans which included, but was not limited to, "Care Plans - Preliminary Policy Statement A preliminary plan of care shall be developed for each resident admitted. Policy interpretation and implementation 1. To assure that the resident's immediate care needs are met and maintained, a		by a team of qualified persons after each assessment. **The corrective action will be monitored to ensure the alleged deficient practice does not recur:** The Nurse Manager will audit the 24 hour sheets daily to review all episodes of wandering or removing the Wander Guard. With each episode the plan of care will be immediately reviewed to ensure a new intervention is in place. **The measures put in place to ensure the alleged deficient practice does not recur:** All licensed staff will be in-serviced by the Director of Nursing on June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander Guard device will be reported to the DON weekly. The DON or	

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	preliminary care plan is developed upon admission....Care Plans - Comprehensive....4. Care plans are revised as changes in the resident's condition dictates...." 3.1-35(d)(1) 3.1-35(d)(2)(A) 3.1-35(d)(2)(B)		designee will report finding of audits on a monthly basis to the Quality Assurance Committee. **Effectiveness of plan:** Facility Quality Assurance Committee will monitor the corrective action on a monthly basis to assure the alleged deficient practice does not recur. Any revisions or changes needed will be reviewed by the Quality Assurance Committee, Administrator, DON.	
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review, interview and observation, the facility failed to supervise a a resident at risk for elopement to prevent her exiting the building. The resident was wearing a Wanderguard alarming device used to alert staff to unsupervised exit (Resident #95) The facility also failed to plan for care related to the resident's habit of removing the Wanderguard, for a resident at risk for elopement who used a Wanderguard to alert staff to unsupervised exit from the	F0323	**3.1-35(d)(1) 3.1-35(d)(2)(A) 3.1-35(d)(2)(B) F323 483.25(h) FREE OF ACCIDENT The facility must ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Action: For those residents found to be affected by the alleged deficient practice.** Resident # 95 was discharged from our facility on 03/22/2011. Resident #8. This resident has a history of removing his Wander Guard device. **The comprehensive plan of care**	06/26/2011

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	building. The deficient practice affected 2 of 4 residents reviewed related to elopement in a sample of 16 (Resident #95 #8) The deficient practice had the potential to affect 5 of 5 residents in a supplemental sample of 8. (Resident #6, 13, 24, 65, 45) Findings include: 1. The clinical record for Resident #95 was reviewed on 5/25/11 at 9:20 a.m. The resident diagnoses included, but were not limited to, Alzheimer's dementia and depression. The resident was admitted to the facility on 3/10/11. The Initial Wandering Assessment Guide dated 3/10/11 indicated the resident should have a 90 day signaling device on for assessment purposes. Wandering behaviors can increase with changes in residence, so consider monitoring the resident until the next assessment period or until you can determine the elopement risk has decreased..."		**will be developed by the nurse immediately after identification of the intent to remove or the history of removal of the Wander Guard device. The interdisciplinary team, and other appropriate staff in disciplines as determined by the residents needs, and the extent practicable, the, participation of the resident, the residents family or the residents legal representative, will periodically review and revise the comprehensive plan of care.** Resident #8 The Risk to Wander Assessment was updated on June 3rd, 2011. The combination of the categories indicated the resident is at risk to wander. He also has a history of removing his Wander Guard device. The plan of care was updated to include a Wander Guard device to the right hand , to the shoe strings of the residents right shoe and to the base of the residents wheel chair. All current residents identified as at risk to wander and with a history of removal of a Wander Guard have had an updated Risk to Wander assessment completed and plan of care reviewed and revised if needed for both. The facility has updated all exit door alarm systems. All exit doors have had installed 1) A Wander Guard device at all exit doors and transition breezeway. 2) Voice alert system to identify	

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	The Social History & Assessment form completed on 3/17/11 by the Social Worker, included but was not limited to, VII (7) Resident's Special Interests: "outdoors" VIII (8). Mental Status Cognitive Alert; Short-Term Memory Poor; XII (12) Adjustment "doing okay but wishes to go home" A History & Physical dated 3/16/11 included, but was not limited to: "Patient was recently admitted for rehab vs. long-term care...She has exhibited a great deal of exit seeking behavior since coming here. She is extremely pleasant but continues to try to leave the facility. In fact, while I was here she tried to slip out the front door...Assessment and Plan...If she continues with her exit seeking behavior then we will have to pursue a locked unit for her safety. However, we will give her a chance to adjust and continue to follow." Nurses Notes, reviewed at this time, included, but were not limited to:		over head the door alarm that has been activated. 3) A yellow blinking light in ceiling at the door that the door alarm has been activated. 4) A STI-Exit Stopper that will sound an additional alarm of a louder and obviously different alarm sound. 5) A pass key alarm key pad to release one door alarm system to avoid alarm activation. The pass key is changed each month to a new pass key. 6) Light alert system at Skilled and ICF nursing stations to identify the door that has been activated. A Wander book will be placed at the both nursing units, ALU unit along with the Village Receptionist to assist with identification of all residents at risk to wander. Each of the above door alarms work together and failure to bypass any of these and open the door will activate the other alarms. These alarms will not reset until a staff member responds to the activated door and uses a key or reset code key for each alarm system. The Wander Guards are a 90 life day system. These are changed every 90 days and PRN by nursing. The Wander Guard active devices are assessed each shift by the charge nurse for efficacy. The Wander Guard door system and additional door alarms are evaluated weekly by Maintenance. Any performance issues will be corrected immediately. **To identify other resident's having the potential**	

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	3/14/11 1600 (4 p.m.) "Res attempted to get out of front door this shift. Asking 'Is this how I get to the 3rd floor?'...Will cont. (continue) to monitor for exit seeking." 3/16/11 1600 "Res. is very confused and will exit seek @ times. Res wheeled herself to the front door this shift and stood up from w/c (wheelchair)..." 3/18/11 8 p "[family member] wants exit seeking behavior discussed with Dr. [named] on visit Tues. 3/22/11." 3/19/11 1300 (1 p.m.) "...Short term memory is very poor. Res gets up from w/c and ambulates ad lib. She needs constant reminder not to ambulate unassisted. She wanders to doors throughout shift and pushes on door till alarm sounds..." 3/20/11 7:30 pm "Res. left facility and was found on the porch of A.L (Assisted Living). Facility policy		**to be affected by the alleged deficient practice:** All residents have the potential to be affected by the alleged deficient practice. Nurse managers will review all care plans for those residents identified at risk to wander / exit seeking by the completion of the risk to wander assessment or with a history of removing their Wander Guard device. A Comprehensive care plan will be in place immediately when identified as at risk to wander. The plan of care will be reviewed by interdisciplinary team, and other appropriate staff in disciplines as determined by the residents needs, and the extent practicable, the, participation of the resident, the residents family or the residents legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment. **The corrective action will be monitored to ensure the alleged deficient practice does not recur:** The Nurse Manager will audit the 24 hour sheets daily to review all episodes of wandering or removing the Wander Guard. With each episode the plan of care will be immediately reviewed to ensure a new intervention is in place. A resident change form will be completed to alert all Department Managers of the instillation of or removal of a Wander Guard device. **The**	

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	was used to search for resident. D.O.N. (Director of Nursing) and Administrator notified. Dr. [named] notified. Son [named] was called and told one on one observation had been initiated for residents safety. He agreed to stay with resident through the night. Head to toe exam of resident revealed no injury and that the wanderguard was missing from residents ankle. A new one was placed on L (left) ankle." Documentation was lacking of a 1:1 tracking log. In interview with the Maintenance Director on 5/26/11 at 10:40 a.m., he measured the distance from the porch at the Assisted Living residence to the door near the smoke shack from which the resident exited. The distance measured 403 feet. The Resident Care Plan dated 3/10/11 included, but was not limited to: "Needs/Problems Res. at risk for elopement;		**measures put in place to ensure the alleged deficient practice does not recur:** All licensed staff will be in-serviced by the Director of Nursing on June 15th and June 16th, 2011 and Staff Development Coordinator on June 22nd and June 24th, 2011 on the Policy and Procedure for developing comprehensive care plans for those residents at risk to wander or who have a history of removing their Wander Guard device. These in-services include the requirement to develop immediately on identification of risk of wander and removal of Wander Guard and to update the plan of care with a new intervention after each episode of wandering /exit seeking and for each time the resident removes their Wander Guard device. The findings of wandering / exit seeking or removing Wander Guard device will be reported to the DON weekly. The DON or designee will report finding of audits on a monthly basis to the Quality Assurance Committee. All Wander Guard audits will be compiled by the Director of Maintenance and the Director of Nursing and reported monthly to the Quality Assurance Committee. **Effectiveness of plan:** Facility Quality Assurance Committee will monitor the corrective action on a monthly basis to assure the alleged deficient practice does not recur.	

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	Goal/Objective Res will have no episodes of unknown whereabouts outs daily thru next review; Approach/Action/Plan wanderguard in place, update wandering assessment quarterly and prn (as needed), update elopement manual, check placement & functioning of wanderguard as scheduled on MAR (Medication Administration Record). Documentation was lacking the resident care plan had been revised after the elopement nor after the increase in exit seeking. In interview with the resident's family member on 5/26/11 at 12:30 p.m., he provided a letter indicating he and/or his nephew sat with his mother until she was transferred. She loved to walk, be outside and wanted to sit on the porch at the Assisted Living. Review of the Behavior Symptoms Detail Report, provided on 5/26/11 at 8:45 a.m., dated March 10 thru March 22, 2011, indicated, "None		Any revisions or changes needed will be reviewed by the Quality Assurance Committee, Administrator, DON, and Maintenance Director.	

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	of these behaviors apply." A sample page provided at this time, included, but was not limited to, "Wandering; Describe the resident's wandering; Was wandering easily altered? Approximately what time did wandering occur?; Was diversion effective for wandering?" Documentation was lacking for the days the resident was exit seeking. 2. The clinical record for Resident #8 was reviewed on 5/24/11 at 10 a.m. The resident diagnoses included, but were not limited to, dementia and cerebral vascular disease. On 5/26/11 at 10:30 a.m., Resident #8 was observed seated in a wheelchair. LPN #3 was observed searching the resident's wrists, ankles and wheelchair after asked to locate the Wanderguard. The wanderguard could not be found. In interview with LPN #3 at 10:35 a.m., she indicated the resident "likes to remove them [the Wanderguard]. He cuts them off."			

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	Signed and dated 4/26/11 Physician's Order for April 2011 included, but was not limited to the following: "wanderguard check placement and function every shift." Review of the Resident Care Plan dated 3/22/11 indicated "Needs/Problems: Res. at risk for elopement; Goal/Objective: Res will have no episodes of unknown whereabouts daily thru next review; Approach/Action/Plan: wanderguard in place, update wandering assessment quartly (sic) and prn (as needed), update elopement manual, check placement & function of wanderguard as scheduled on MAR. Documentation was lacking of a problem and interventions for the resident cutting off his wanderguard. 3. On 5/26/11 at 8:55 a.m., the Director of Nursing provided the current list of residents utilizing a			

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	Wanderguard. The list included Residents #8, #42, #14, #6, #13, #24, #65, and #45. 3.1-45(a)(2)			
F0364 SS=F	Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to ensure food was served at appropriate temperatures for 1 of 3 dietary observations. This deficient practice affected 5 of 6 residents at the Group Interview (Residents #100, #101, #102, #103, and #104) and had the potential to affect 79 of 79 residents, who received meals from the kitchen. Findings include: During the confidential group meeting on 5/23/2011 at 1:30 p.m., Residents #100, #101, #102, #103, and #104, who the Activity Assistant #1 indicated were alert, oriented and reliable, indicated the food was not usually warm when served. They indicated that even when served right from the steam table in the dining room,	F0364	**Tag F-364: Nutritive Value/Appear, Palatable/Prefer Temp:** Resident Concerns Corrective action for those residents affected by the alleged deficiency Five of six residents stated that they were affected by alleged deficiency. CDM checked all six of these residents for significant weight loss, a noticeable decline in meal consumption and for complaints of GI disturbance. No notable changes could be identified.Identify residents who have potential to be affected by alleged deficiency and corrective action for those residents. All residents have potential to be affected by the alleged deficiency. Primary care staff have been interviewed to determine if any wide spread complaints of GI disturbances and none have been noted. CDM in-serviced staff on May 24,2011	06/26/2011

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	the food still was not always warm. The residents indicated the cold food occurred whether they ate in the main dining room or in their rooms. When asked if they had brought this to the administration or dietary manager's attention, the residents indicated they had during their Resident Council meetings with Activity Assistants #1 and #2, but nothing had been done about it. Review of the February through May 2011 Resident Council minutes failed to note documentation of the residents' concerns about the temperature of the food. During the daily exit meeting with the Administrator and the Director of Nursing on 5/25/2011 at 12:20 p.m., they indicated they were not aware there had been a problem with the food not being warm enough when served. On 05/24/11 at 7:57 a.m., the breakfast meal was observed being served in the main dining room. In interview with the cook at this time, she indicated the food temperatures were documented in the kitchen prior to bringing the steam table to the dining room. The Dietary Manager was present at this time and indicated the food temperatures are also to be taken and documented when the steam table arrives in the dining room and prior to service in		on policy & procedure for taking temperatures on the healthcare steam table. Temperatures are to be taken and recorded 3 times each meal (before beginning, when they get to dining room and at the end of service). The in-service also included the policy and procedure on how to re-heat food to the appropriate temperature. All cooks were in-serviced on the appropriate holding temperature per the serve safe guidelines.Corrective actions will be monitored to ensure the alleged defiant act does not occur. 1. All staff in-serviced on May 24,2011 and to be in-serviced again on June 17,2011 regarding appropriate temperature of foods and when to take temperatures2. Cooks will be monitored daily by CDM or designee to ensure they are taking food temperatures. 3. CDM or designee will be doing daily rounds to ensure cooks are recording temperatures 3 times per meal and that these temperatures meet the required temperature per the serve safe guidelines.4. CDM or designee will record findings on a daily audit sheet for 3 months and then randomly after that. Any deviation will be corrected immediately and responsible employee educated. Audit and findings to be reported to the QA team in the monthly meeting.5. Director of Activities will report any resident concerns coming out of monthly resident	

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	the dining room. The cook indicated she failed to take temperatures after the steam table arrived in the dining room prior to serving. The Dietary Manager instructed the cook to to take the food temperatures at this time. The temperature of the fried eggs measured 126.3 Fahrenheit, the fried potatoes measured 107.3 F. in one area of the steam table pan and 155.9 degrees in another area of the same pan. When queried as to the appropriate temperature of the fried eggs, the cook indicated she did not know. The dietary manager provided a copy of the Policy & Procedure Food temperatures at 4:20 p.m., on 05/24/11, which was reviewed at this time. Under Procedure: #3. "Temperatures of the food are to be taken again before you start serving the dining room...." 3.1-21(a)(2)		council meeting to CDM with a Resident Council Concern Form. CDM will respond on the appropriate form and return the form to the Activity Director or designee after investigating the issue not to exceed five (5) days. The CDM will be available to answer questions regarding the issue from the Resident Council as requested by the Council. The Activity Director or designee will introduce the Resident Council Concern Form at the next scheduled Council Meeting to inform the Council of Action Taken.Effectiveness of the plan. Any revisions needed will be evaluated by the QA team, Dietary Manager, Consultant Dietician and the Administrator.**Tag F-364: Nutritive Value/Appear, Palatable/Prefer Temp:** Food Temperatures Corrective action for those residents affected by the alleged deficiency No residents have been affected by alleged deficiency. Primary staff have been interviewed for complaints of GI disturbance. None have been reported. Identify residents who have potential to be affected by alleged deficiency and corrective action for those residents. All residents have potential to be affected by the alleged deficiency. Primary care staff have been interviewed to determine if any wide spread complaints of GI disturbances and none have been noted. CDM	

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			in-serviced staff on May 24,2011 on policy & procedure for taking temperatures on the healthcare steam table. Temperatures are to be taken and recorded 3 times each meal (before beginning, when they get to dining room and at the end of service). The in-service also included the policy and procedure on how to re-heat food to the appropriate temperature. All cooks were in-serviced on the appropriate holding temperature per the serve safe guidelines. Corrective actions will be monitored to ensure the alleged defiant act does not occur. 1. All staff in-serviced on May 24,2011 and to be in-serviced again on June 17,2011 regarding appropriate temperature of foods and when to take temperatures2. Cooks will be monitored daily by CDM or designee to ensure they are taking food temperatures. 3. CDM and/or designee will be doing daily rounds to ensure cooks are recording temperatures 3 times per meal and that these temperatures meet the required temperature per the serve safe guidelines.4. CDM or designee will record findings on a daily audit sheet for 3 months and then randomly after that. Any deviation will be corrected immediately and responsible employee educated. Audit and findings to be reported to the QA team in the monthly meeting. Effectiveness of the plan. Any revisions needed will be	

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	155191	A. BUILDING 00 B. WING	05/27/2011

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WESTMINSTER HEALTH CARE CENTER	2210 GREENTREE NORTH CLARKSVILLE, IN47129

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			evaluated by the QA team, Dietary Manager, Consultant Dietician and the Administrator.**Completion Date:** 6/26/11	
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure hands were washed, equipment was clean, rinse temperatures were 180 degrees in the dishwasher, and hot food was served at 140 degrees Fahrenheit (F) on 3 of 3 dietary observations. This deficient practice had the potential to affect 79 of 79 residents receiving meals from the dietary department. Findings include: On 05/23/11 between the hours of 9:46 a.m. and 10:11 a.m., the following was observed: 1. The floor in front of the grill, stove and fryer was soiled with grease and pieces of eggshell. The hood over the stove was soiled with heavy dust and grease. In interview with the Assistant Dietary Manager (ADM) at this time she indicated the hood is cleaned every 2 weeks.	F0371	Tag F-371: Food Procure, Sttiore/Prepare/Serve -Sanittiary Floors and Hood Systtiem Correcttive acttion ftor ttihose residenttis aftecttied by ttihe alleged deftciency No residenttis have been aftecttied by alleged deftciency. Primary sttiaft have been inttierviewed ftor complainttis oft GI disttiurbandNone have been reporttied Identtifty residenttis who have pottienttial ttio be aftecttied by alleged deftciency and correcttive acttion ftor ttihose residenttis All residenttis have pottienttial ttio be aftecttied by ttihe alleged deftciency Primary care sttiaft have been inttierviewed ttio dettiermine ift any wide spread complainttis oft GI disttiurbances and none have been nottiedCDM ttio in-service sttiaft on June17,2011 on importtiance oft keeping area and ftoors clean atti all ttimesThe in-service will include ttihe importtiance oft keeping ttihe hood systtiem ftree ftrom dustti and grease	06/26/2011

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	2. The Robot Coupe (used to puree food) stored as clean was wet on the inner surface. The ADM indicated the Robot Coupe is supposed to stay on the drying shelf to drain and dry. 3. The rinse temperature in the dishwasher failed to reach 180 degrees Fahrenheit in two cycles. The temperature reached 160 degrees for 2 cycles. The dishwasher indicated at this time the rinse temperature should measure 180 degrees. 4. Two steam table pans stacked together and stored as clean were wet and soiled with food on the inner surfaces. 5. On 05/24/11 at 7:57 a.m., Cook #1, failed to take the food temperatures at the serving line prior to serving food. When requested to measure the temperatures at this time the fried eggs measured 126.3 degrees F., and the potatoes measured 107.1 degrees F. in one area of the pan and 155.9 F. in another area of the same pan. When Cook #1, was queried as to what the proper temperature of the fried eggs should be, she replied she did not know. 6. On 05/27/11 at 9:33 a.m., the following was observed: the ceiling vent over clean dishes by the dish machine was		Correcttive acttions will be monittiored ttio ensure ttihe alleged deftantti actti does notti occur. 1. Hood Venttis were ttiaken down and cleaned immediattiely 2. Floors will be sweptti and mopped randomly ttihrough outti ttihe day as needed. The hood systtiem is on ttihe biweekly cleaning schedule ttio ensure a deep cleaning oft ttihe systtiem 3. CDM and/or designee will be doing daily auditti rounds ttio ensure ftoors are keptti clean and ttihe hood systtiem is ftree ftrom dustti and grease CDM ttio monittior biweekly cleaning schedules ttio ensure ttihey are being cleaned appropriattiely 4. CDM or designee will record ftndings on a daily auditti sheetti fBor monttihs and ttihen randomly after ttihatAny deviattion will be correcttied immediattiely and responsible employee educattiedAuditti and ftndings ttio be reporttied ttio ttihe QA ttieam in ttihe monttihly meetting Eftecttiveness oft ttihe plan Any revisions needed will be evaluattied by ttihe QA ttie, Dietttiary Manager, Consulttiantti Diettician and ttihe Administtirattior Tag F-371: Food Procure,	

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	soiled with heavy dust. 7. On 5/27/11 at 9:43 a.m., Cook #2, lifted the lid of the trash container and without washing her hands the cleaned the prep counter with a cloth. 3.1-21(i)(3)		Sttiore/Prepare/Serve -Sanittiary Robotti Coupe Correcttive acttion ftor ttihose residenttis aftecttied by ttihe alleged deftciency No residenttis have been aftecttied by alleged deftciency. Primary sttiaft have been inttierviewed ftor complainttis oft GI disttiurbances. None have been reporttied Identtifty residenttis who have pottienttial ttio be aftecttied by alleged deftciency and correcttive acttion ftor ttihose residenttis All residenttis have pottienttial ttio be aftecttied by ttihe alleged deftciency Primary care sttiaft have been inttierviewed ttio dettiermine ift any wide spread complainttis oft GI disttiurbances and none have been nottied. CDM ttio in-service sttiaft on June 17,2011 on importtiance oft letting ttihe robotti coupe air dry and being sure itti is clean and complettiely dry beftore putting itti away Correcttive acttions will be monittiored ttio ensure ttihe alleged deftantti actti does notti occur. 1. Robotti Coupe was placed back on ttihe drying rack immediattiely 2. Potti and pan area will be monittiored daily by CDM or designee ttio be sure ttihatti all potts, pans and robotti coupeare clean and complettiely dry beftore ttihey are putti away.	

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			3. CDM and/or designee will be doing daily rounds ttio ensure all dishes including pottis, pans and robotti coupe are clean and dry 4. CDM or designee will record ftndings on a daily auditti sheetti for monttihs and ttihen randomly after ttihat. Any deviattion will be correcttied immediattiely and responsible employee educattied. Auditti and ftndings ttio be reporttied ttio ttihe QA ttieam in ttihe monttihly meetting Eftecttiveness oft ttihe plan Any revisions needed will be evaluattied by ttihe QA ttieam, Dietttiary Manager, Consulttiantti Diettician and ttihe Administtirattior Tag F-371: Food Procure, Sttiore, Prepare/Serve -Sanittiary Dishwasher Correcttive acttion ftor ttihose residenttis aftecttied by ttihe alleged deftciency No residenttis have been aftecttied by alleged deftciency. Primary sttiaft have been inttierviewed ftor complainttis oft GI disttiurbance. None have been reporttied Identtifty residenttis who have pottienttial ttio be aftecttied by alleged deftciency and correcttive acttion ftor ttihose residenttis All residenttis have pottienttial ttio be	

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			aftecttied by ttihe alleged deftciency Primary care sttiaft have been inttierviewed ttio dettiermine ift any wide spread complainttis oft GI disttiurbances and none have been nottiedCDM ttio in-service sttiaft on June17,2011 on importtiance oft rinse ttiemperattiure oft ttihe dishwasher The in-service will include procedure ftor whatti ttio do when ttihe dishwasher does notti meetti ttihe appropriattie ttiemperattiure Correcttive acttions will be monittiored ttio ensure ttihe alleged deftantti actti does notti occur. 1. The dishwasher was empttied immediattiely and reftlled and ttiemperattiure was appropriattie atti ttihatti ttime.Hobartti came in on May 23,2011 ttio check ttihe boosttier heattier 2. Temperattiures are ttio be ttiaken and recorded on a ttiemperattiure log ttiwo ttimes daily. 3. CDM and/or designee will be doing daily rounds ttio ensure dishwasher ttiemperattiures are reaching ttihe appropriattie ttiemperattiure 4. CDM or designee will record ftndings on a daily auditti sheetti f3or monttihs and ttihen randomly after ttihatAny deviattion will be correcttied immediattiely and responsible employee educattiedAuditti and ftndings ttio be reporttied ttio ttihe QA ttieam in ttihe monttihly meetting Eftecttiveness oft ttihe plan	

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			Any revisions needed will be evaluattied by ttihe QA ttiea, Dietttiary Manager, Consulttiantti Diettician and ttihe Administtirattior Tag F-371: Food Procure, Sttiore/Prepare/Serve -Sanittiary Sttieam ttiable pans Correcttive acttion ftor ttihose residenttis aftecttied by ttihe alleged deftciency No residenttis have been aftecttied by alleged deftciency. Primary sttiaft have been inttierviewed ftor complainttis oft GI disttiurbandNone have been reporttied Identtifty residenttis who have pottienttial ttio be aftecttied by alleged deftciency and correcttive acttion ftor ttihose residenttis All residenttis have pottienttial ttio be aftecttied by ttihe alleged deftciency Primary care sttiaft have been inttierviewed ttio dettiermine ift any wide spread complainttis oft GI disttiurbances and none have been nottiedCDM ttio in-service sttiaft on June17,2011 on importtiance oft making sure pottis and pans are clean and dry beftore being putti away Correcttive acttions will be monittiored ttio ensure ttihe alleged deftantti actti does notti occur. 1. The ttiwo sttieam ttiable pans were	

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			removed immediattiely and re-washed. 2. Potti and pan area will be monittiored daily by CDM or designee ttio be sure ttihatti all pottis, pans and robotti coupeare clean and complettiely dry beftore ttihey are putti away. 3. CDM and/or designee will be doing daily rounds ttio ensure all dishes including pottis, pans and robotti coupe are clean and dry 4. CDM or designee will record ftndings on a daily auditti sheetti for 3 monttihs and ttihen randomly after ttihat. Any deviattion will be correcttied immediattiely and responsible employee educattied. Auditti and ftndings ttio be reporttied ttio ttihe QA ttieam in ttihe monttihly meetting Eftecttiveness oft ttihe plan Any revisions needed will be evaluattied by ttihe QA ttiea, Dietttiary Manager, Consulttiantti Diettician and ttihe Administtirattior Tag F-371: Food Procure, Sttiore, Prepare/Serve -Sanittiary Food Temperattiures Correcttive acttion ftor ttihose residenttis aftecttied by ttihe alleged deftciency No residenttis have been aftecttied by alleged deftciency. Primary sttiaft have been inttierviewed ftor complainttis oft GI disttiurbance. None	

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			have been reporttied Identtifty residenttis who have pottienttial ttio be aftecttied by alleged deftciency and correcttive acttion ftor ttihose residentt is All residenttis have pottienttial ttio be aftecttied by ttihe alleged deftciency Primary care sttiaft have been inttierviewed ttio dettiermine ift any wide spread complainttis oft GI disttiurbances and none have been nottied CDM in-serviced sttiaft on May 24,2011 on policy & procedure ftor ttiaking ttiemperattiures on ttihe healttihcare sttieam ttiable. Temperattiures are ttio be ttiaken 3 ttimes each meal (beftore beginning, when ttihey getti ttio dining room and atti ttihe end oft servjice. The in-service also included ttihe policy and procedure on how ttio reheatti ftood ttio ttihe appropriattie ttiemperattiure. All cooks were in-serviced on ttihe appropriattie holding ttiemperattiure per ttihe serve safte guidelines Correcttive acttions will be monittiored ttio ensure ttihe alleged deftantti actti does notti occur. 1. All sttiaft in-serviced on May 24,2011 and ttio be in-serviced again on June 17,2011 regarding appropriattie ttiemperattiure oft ftoods and when ttio ttiake ttiemperattiures 2. Cooks will be monittiored daily by CDM or designee ttio ensure ttihey are ttiaking ftood ttiemperattiures 3. CDM and/or designee will be doing daily rounds ttio ensure cooks	

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			are recording ttiemperattiure3sttimes per meal and ttihatti ttihese ttiemperattiures meetti ttihe required ttiemperattiure per ttihe serve safte guidelines. 4. CDM or designee will record ftndings on a daily auditti sheetti f3or monttihs and ttihen randomly after ttihatAny deviattion will be correcttied immediattiely and responsible employee educattiedAuditti and ftndings ttio be reporttied ttio ttihe QA ttieam in ttihe monttihly meetting 5. Directtior oft Acttivitties will reportti any residentti concerns coming outti oft monttihly residentti council meetting ttio CDM wittih a Residentti Council Concern Form. CDM will respond on ttihe appropriattie4torm and rettiurn ttihe ftorm ttio ttihe Acttivittiy Directtior or designee after investtigatting ttihe issue nottittio exceed ftve(5) days. The CDM will be available ttio answer questtions regarding ttihe issue ftrom ttihe Residentti Council as requesttied by ttihe CouncilThe Acttivittiy Directtior or designee will inttiroduce ttihe Residentti Council Concern Form atti ttihe nextti scheduled Council Meetting ttio inftorm ttihe Council oft Acttion Taken Eftecttiveness oft ttihe plan Any revisions needed will be evaluattied by ttihe QA ttiea Dietttiary Manager, Consulttiantti Diettician and ttihe Administtirattior Tag F-371: Food Procure,	

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			Sttiore/Prepare/Serve -Sanittiary Ceiling Venttis Correcttive acttion ftor ttihose residenttis aftecttied by ttihe alleged deftciency No residenttis have been aftecttied by alleged deftciency. Primary sttiaft have been inttierviewed ftor complainttis oft GI disttiurbandNone have been reporttied Identtifty residenttis who have pottienttial ttio be aftecttied by alleged deftciency and correcttive acttion ftor ttihose residenttis All residenttis have pottienttial ttio be aftecttied by ttihe alleged deftciency Primary care sttiaft have been inttierviewed ttio dettiermine ift any wide spread complainttis oft GI disttiurbances and none have been nottiedCDM ttio in-service sttiaft on June17,2011 on importtiance oft keeping all venttis ftree ftrom dustti and debris Correcttive acttions will be monittiored ttio ensure ttihe alleged deftantti actti does notti occur. 1. Ceiling ventti was cleaned immediattiely 2. Ceiling venttis are on cleaning scheduled ttio be cleaned biweekly 3. CDM and/or designee will be doing daily rounds ttio ensure all ceiling venttis are ftree ftrom dustti 4. CDM or designee will record ftndings on a daily auditti sheetti fBor monttihs and ttihen randomly after	

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			ttihatt Any deviattion will be correcttied immediattiely and responsible employee educattied Auditti and ftndings ttio be reporttied ttio ttihe QA ttieam in ttihe monttihly meetting Eftecttiveness oft ttihe plan Any revisions needed will be evaluattied by ttihe QA ttieam Dietttiary Manager, Consulttiantti Diettician and ttihe Administtirattior Tag F-371: Food Procure, Sttiore & Prepare/Serve -Sanittiary Hand washing Correcttive acttion ftor ttihose residenttis aftecttied by ttihe alleged deftciency No residenttis have been aftecttied by alleged deftciency. Primary sttiaft have been inttierviewed ftor complainttis oft GI disttiurbances None have been reporttied Identtifty residenttis who have pottienttial ttio be aftecttied by alleged deftciency and correcttive acttion ftor ttihose residenttis All residenttis have pottienttial ttio be aftecttied by ttihe alleged deftciency Primary care sttiaft have been inttierviewed ttio dettiermine ift any wide spread complainttis oft GI disttiurbances and none have been nottiedCDM ttio	

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			in-service sttiaft on June 17,2011 on importtiance oft hand washing. The in-service will include ttihe policy and procedure ftor hand washing and ttihe appropriattie ttimes in which ttio wash hands. Correcttive acttions will be monittiored ttio ensure ttihe alleged deftantti actti does notti occur. 1. All sttiaft in-service on June 17,2011. 2. Sttiaft will be monittiored daily ttio ensure all sttiaft are washing ttiheir hands appropriattiely and when needed. 3. CDM and/or designee will be doing daily rounds ttio ensure all sttiaft are ftollowing ttihe policy and procedure. 4. CDM or designee will record ftndings on a daily auditti sheetti fbor monttihs and ttihen randomly after ttihat. Any deviattion will be correcttied immediattiely and responsible employee educattied. Auditti and ftndings ttio be reporttied ttio ttihe QA ttieam in ttihe monttihly meetting Eftecttiveness oft ttihe plan Any revisions needed will be evaluattied by ttihe QA ttiea, Dietttiary Manager, Consulttiantti Diettician and ttihe Administtirattior	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and record review, the facility failed to ensure nurses washed hands during the medication pass between residents for 2 of 5 licensed nurses and 1 Qualified Medication Aide observed.	F0441	F 441 3.1-21(i)(3) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS **The facility has established and will maintain an Infection Control Program**	06/26/2011

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	155191	A. BUILDING 00 B. WING	05/27/2011

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	This deficient practice affected 1 of 1 resident observed in a sample of 16 and 3 of 3 residents in a supplemental sample of 8 observed receiving medications. (Resident #50, #77, #78, #80) Findings include: On 05/24/11 at 7:39 a.m., Licensed Practical Nurse (LPN) #1, was observed administering medications to Resident #50. The LPN administered 16 pills to the resident, and put on gloves and placed the resident's hearing aids in her ears. Without washing her hands, using hand sanitizer or changing gloves, she put eye drops in both of the resident's eyes. On 05/25/11 between 5:27 a.m. and 5:42 a.m., LPN #2, was observed to administer medications to Resident #77. The LPN placed the medications in a cup and entered the resident's room. The LPN raised the head of the bed and assisted the resident to take the medications. The LPN returned to the medication cart and prepared medication for Resident #78 without washing his hands or using hand sanitizer. He entered the resident's room raised the head of the bed and assisted the resident to take the medication. He again returned to the medication cart and prepared medication for Resident # 80. He entered the resident's room and		**designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Resident # 50** No actual harm identified to resident # 50 due to the alleged deficient practice.The nurse responsible for the alleged deficient practice , and all other Licensed and Qualified Aids have been in-serviced on Hand Sanitation with med pass on May 25, 2011. **Resident # 77** No actual harm identified to resident # 77 due to the alleged deficient practice.The nurse responsible for the alleged deficient practice , and all other Licensed and Qualified Aids have been in-serviced on Hand Sanitation with med pass on May 25, 2011. **Resident # 78** No actual harm identified to resident # 78 due to the alleged deficient practice.The nurse responsible for the alleged deficient practice , and all other Licensed and Qualified Aids have been in-serviced on Hand Sanitation with med pass on May 25, 2011. **Resident # 80** No actual harm identified to resident # 80 due to the alleged deficient practice.The nurse responsible for the alleged deficient practice , and all other Licensed and Qualified Aids have been in-serviced on Hand Sanitation with med pass on May 25, 2011. **To identify other resident's having the potential**	

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	assisted the resident to take the medication. The nurse failed to wash his hands or use hand sanitizer between Residents #77, #78 and #80. On 05/27/11 at 8:55 a.m., in interview with Staff Development Coordinator (SDC) and review of the Handwashing/Hand Hygiene provided by the SDC at this time, she indicated during the medication pass hands are to be washed or instant sanitizer is to be used between residents. Under general guidelines of the "Handwashing/Hand Hygiene Policy/Procedure" " Bullet #4 : " If hands are not visibly soiled, use an alcohol-based hand rub for all the following situations: a. Before direct contact with residents; b. Before donning sterile gloves; c. Before performing any non-surgical invasive procedures; d. Before preparing or handling medications;...." 3.1-18(1)		**to be affected by the alleged deficient practice:** All residents have the potential to be affected by the alleged deficient practice. Primary care staff was in-serviced on Hand Sanitation on May 25th 2011 by the SCC and all primary care staff will be in-serviced on June 15th and June 16th 2011 by the Director of Nursing and the Staff Development Coordinator on June 22nd and June 24th 2011 on the policy and procedure for Hand Sanitation. **The corrective action will be monitored to ensure the alleged deficient practice does not recur:** All nurse manager will complete monthly audits of Hand Sanitation with a med pass observation on each nurse and qma. An audit will be completed by the Director of Nursing monthly with the findings of the med pass and hand sanitation observation.The staff development coordinator will complete two random hand sanitations observations weekly and will audit the hand sanitation observations monthly.Any observation of inappropriate hand sanitation with med pass will be immediately corrected and the responsible staff member will be re-educated on proper hand sanitation. **The measures put in place to ensure the alleged deficient practice does not recur:** All primary care staff were in-serviced on proper hand	

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			sanitation on May 25th 2011 by SDC and will be re-in-serviced on proper hand sanitation by the Director of Nursing on June 15th and 16th 2011. The SDC will also give all primary care staff and in-service on June 22nd and 24th, 2011 on proper hand sanitation. All nurse manager will complete monthly audits of Hand Sanitation with a med pass observation on each nurse and qma. An audit will be completed by the Director of Nursing monthly with the findings of the med pass and hand sanitation observation.The staff development coordinator will complete two random hand sanitations observations weekly and will audit the hand sanitation observations monthly.Any observation of inappropriate hand sanitation with med pass will be immediately corrected and the responsible staff member will be re-educated on proper hand sanitation.The Director of Nursing or designee will report the finding of monthly hand sanitation audits to the Quality Assurance Committee. The SDC will report the findings of the two random weekly hand sanitation audits to the Quality Assurance Committee on a monthly basis. **Effectiveness of plan:** the Quality Assurance committee will monitor the corrective action on a monthly basis to assure the alleged deficient practice does not recur. Any revisions or changes will be reviewed by the	

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			Quality Assurance Committee, Administrator , DON and SDC.	